BUREAU OF INSURANCE
BASIS STATEMENT AND SUMMARY OF COMMENTS
ADOPTION OF 02-031 C.M.R. CHAPTER 851
CLEAR CHOICE DESIGNS FOR INDIVIDUAL AND SMALL GROUP HEALTH PLANS

Superintendent of Insurance Eric Cioppa hereby adopts Chapter 851, "Clear Choice Designs for Individual and Small Group Health Plans." This rule implements provisions of the Insurance Code added by P.L. 2019, ch. 653, An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine.

Pursuant to a Notice of Rulemaking issued on February 9, 2021, Superintendent Cioppa held a public hearing on March 12, 2021, and the public comment period was open until March 23, 2021 at 4:30 p.m.

The primary purpose of the proposed rule is to develop standardized health plan cost-sharing designs as set out in 24-A M.R.S. §2793. At this time, Section 2793 applies to both the individual and small group markets. However, the Legislature will be considering whether to apply Clear Choice designs exclusively to the individual market until the individual and small group markets are pooled under 24-A M.R.S. § 2792, in light of the decision to defer implementation of the pooled market until 2023.

Because Clear Choice will, in any event, be proceeding in the individual market in 2022, carriers need clarity as to what will be required. Therefore, rather than withdrawing this proposed rule until the Legislature has had the chance to act, the Superintendent is adopting the rule without making any changes at this time to provisions relating to the small group market. Those provisions will be addressed in a subsequent rulemaking, because we do not yet have statutory authority to defer the applicability of Clear Choice to the small group market until the pooled market is implemented.

A. The following person testified at the hearing:

Kristine M. Ossenfort, Esq.
Senior Government Relations Director
Anthem Blue Cross Blue Shield of Maine

B. The following persons submitted written comments on or before March 23, 2021:

Robert Kennedy
Maine Insurance Broker
Acadia Benefits Inc.

Allyson Perron Drag
Government Relations Director
American Heart Association (AHA)/ Stroke Association

Nancy Johnson, JD, CLU, ChFC, AIE
Vice President, Compliance & Regulatory Affairs
Community Health Options

Hilary Schneider
Maine Director of Government Relations
American Cancer Society (ACS) Cancer Action Network

David R. Clough
Maine State Director
National Federation of Independent Business

Peter M. Gore
Executive Vice President
Maine State Chamber of Commerce

Steve Butterfield
Regional Director of Government Affairs
The Leukemia & Lymphoma Society

Katherine D. Pelletreau
Executive Director
Maine Association of Health Plans (MeAHP)

Kristine M. Ossenfort, Esq.
Senior Government Relations Director
Anthem Blue Cross Blue Shield of Maine

Bill Whitmore
Maine Market VP
Harvard Pilgrim Health Care

C. Summary of comments and Bureau of Insurance responses:

1. General Comments

Many comments were related to Clear Choice plans for small group employers. As noted earlier, that will be the subject of a separate rulemaking proposal. It is premature to take any action in response to these comments at this time, but we will consider them carefully when developing our next rulemaking proposal, which will be issued as soon as practicable.

2. Comments on Proposed Cost-Sharing Design Chart:

While the specific plan designs are not part of this rule, the proposed plan designs for 2022 have been circulated for comment concurrently with the proposed rule, and the Bureau has addressed those comments as follows. For future plan years, Section 5(1) establishes a process for annual updates,

Comment: Mr. Kennedy suggests that urgent/convenience care should not be subject to the deductible. He explains that for many Mainers who don't have a Primary Care Physician, these

facilities provide a valuable option to seek quality care at a low-cost provider rather than going to the Emergency Room.

Bureau Response: The benefit plan chart has been changed to provide coverage before the deductible for urgent care, subject to a copayment.

Comment: Mr. Kennedy suggests that specialist visits should not be subject to the deductible, stating that this is a common feature in the plans he sells.

Bureau Response: The number of plans with specialist visits outside the deductible has been increased from 2 to 6. The one remaining non-HSA plan where specialist visits are subject to the deductible (Bronze $7,000) has been changed from a copayment inside the deductible to coinsurance after the deductible.

Comment: Mr. Kennedy expressed concern that making prescriptions subject to the deductible creates a financial hardship for policyholders and may lead to people to not take their medications that would keep them healthy and avoid costly healthcare.

Bureau Response: Tier 1 or generic prescriptions are covered before the deductible in all Clear Choice plans and the Gold plan option has all prescriptions covered before the deductible. Due to premium impact concerns the Bureau proposed a variety of options to meet consumers' need for benefits at reasonable cost.

Comment: AHA and ACS support copayments in place of coinsurance for specialty tier prescription drugs. They said coinsurance is not transparent to consumers and does not meet the intended purpose of the standardization of plan designs, to allow a better opportunity to compare plan options, nor does it meet the opportunity to create higher quality plan options for consumers. They asked the Bureau to explore copayment-only structures for prescription drug coverage and for office visits for all standardized plan options, including HSA plans.

Bureau Response: The plan chart includes a number of different cost-sharing structures to provide consumers a choice of options depending on premium and cost share. There is a Gold plan with a copayment before the deductible for all prescriptions. The Bureau will continue to review the plans and accept suggestions for the 2023 plans.

Comment: AHA and ACS believe that allowing more than a handful of alternative plan designs will be confusing to the consumer and antithetical to the stated intent of the legislation. They urge the Bureau to consider whether all the proposed plan designs are necessary. By contrast, Harvard Pilgrim, the Chamber of Commerce, and Mr. Kennedy expressed concern that there were too few choices, particularly outside the Marketplace.

Bureau Response: We recognize both concerns. In the first year for Clear Choice plans it is important to avoid disruption in the market, so we have attempted to preserve a range of options based on what is available currently. This will give us the opportunity to assess which plans work the best for consumers, including the alternative plans carriers choose to offer, as we decide what options to make available in future years.

Comment: Anthem asked for confirmation that not all Clear Choice plans have to be offered and not all plans offered must be actively marketed.

Bureau Response: Anthem is correct. Carriers are not required to offer or actively market all the plans.

Comment: Community Health Options commented that the Clear Choice Cost-Sharing Plan Designs document does not have Actuarial Values or CMS AV standards for the 12 plans. The rule has a color scheme with some boxes in white, others in yellow, and some in yellow with an asterisk. They requested clarification regarding the difference in cost sharing contemplated between a yellow box and a yellow box with an asterisk.

Bureau Response: Those suggested clarifications have been made to the Plan Chart document.

Comment: Community Health Options stated its understanding that when a service has a copayment, the design expectation is that the remainder of the allowed amount for the service is subject to the plan deductible, and expressed concern that this structure is unusual and "will be abrasive for plan members."

Bureau Response: This is not accurate. Some coverage is provided before the deductible, with a copayment as the only cost sharing, such as primary care and behavioral health office visits. Other copayments are charged only after reaching the deductible. There are no charges where the copayment is made and then a deductible must be reached.

3. Specific Section Comments:

Section 3, definitions

Comment: Anthem suggested that the definition of "AV" be amended to include a reference to the AV as calculated using the AV calculator published by CMS. They also urged the Bureau to set the default AV for each of the Clear Choice plans. This is approach taken in other states with respect to standardized plan designs and avoids the potential for different results among carriers. Anthem also asked for clarification that if the lowest Silver is offered as a tiered plan, the AV applies to the Clear Choice tier.

Bureau Response: The rule has been amended to include reference to the AV calculator in the definition of AV. Each carrier is still expected to certify compliance that each plan offered meets the metal level requirements. AV is calculated for the whole plan, not just the Clear Choice portion.

Comment: Anthem requested the Bureau to include a definition of "plan" in order to clarify what constitutes a "plan."

Bureau Response: 24-A M.R.S. § 2791 incorporates by reference the longstanding Insurance Code definition of "plan," which precedes the Affordable Care Act (ACA) and treats each

contract of coverage as a "plan." The ACA regulations that group similar contracts into "plans" and "products" are not relevant to the purposes of this rule. Instead, we have sought to clarify explicitly the grouping that is relevant to the Clear Choice program: identifying when two different policy or contract forms are treated as conforming to the same Clear Choice Design or to the same Alternative Plan Design.

Section 4 General Provisions

Comment: Anthem had questions about Section 4(3) (misnumbered in the Proposed Rule as 4(4)), which requires consumers in existing plans to be mapped into the most similar Clear Choice or alternative plan, and provides a limited safe harbor outlining when that mapping will be treated as a "benefit modification required by law" for purposes of Maine's guaranteed renewal requirements. In particular, Section 4(3)(B) makes the safe harbor unavailable if the carrier chooses not to offer a more similar Clear Choice design. Anthem asked the Bureau to clarify what constitutes "more similar" and to explain how members should be mapped. Anthem suggested that Section 4(3)(B) be deleted and replaced with a requirement that allows a carrier to map the member or group to the closest plan offered by the carrier and requiring the carrier to provide notices similar to those required by 24-A M.R.S. § 2850-B(3)(G)(2) and (3)—that carriers notify the policyholder that they can purchase any plan offered.

Bureau Response: The transition to Clear Choice raises two related but different mapping issues. First, if an enrollee's 2021 plan will not be offered in 2022, the carrier must map the enrollee into the most similar 2022 plan. This is no different from what happens every time plans are discontinued or consolidated. The Bureau will work with carriers on the most appropriate mapping, and it is important to keep in mind that mapping is not mandatory. If the enrollee would prefer a different plan, he or she is free to choose that plan instead of the replacement initially offered by the carrier. As long as the enrollee has clear notice of the available alternatives, there is little risk of serious harm. However, the carrier's voluntary decision not to offer a particular plan is not an issue that can be fully addressed through notice. Mapping an enrollee from a legacy plan to the most similar Clear Choice plan is the result of the Clear Choice program and should be treated as a modification required by law. However, if the most similar Clear Choice plan is not available, that is the result of a voluntary action by the carrier. We recognize that there are situations where it is not clear whether the carrier's requested mapping has bypassed a more similar Clear Choice design. In that case, we will defer to the carrier's reasonable judgment as we work with the carrier on the appropriate mapping.

Comment: Community Health Options asked if an individual Member coming from a PPO plan be cross walked to an HMO plan or vice versa if that plan is more similar in benefit design than any other Clear Choice product?

Bureau Response: Section 4(3)(B) has been amended to clarify this point. A cross-walk between PPO and HMO coverage is not a minor modification, and does not qualify for the safe harbor because it is not required in any way by the transition to Clear Choice. A carrier offering both PPO and HMO coverage may offer both HMO and PPO versions of the same cost-sharing design, without reducing the number of other choices it is allowed to offer.

Comment: Anthem asked the Bureau to confirm that CSR plan designs are to be developed by the carrier.

Bureau Response: Yes, that is correct, subject to the ACA requirements for CSR design. A new Subparagraph (2) has been added to Section 4(2)(E), clarifying this point.

Comment: Community Health Options seeks additional clarification regarding the intent of Section 4(2)(A), which provides that the Clear Choice standards should not be construed as creating any new or additional benefit or provider mandates; and that a plan's failure to provide a benefit in a Clear Choice Design does not prevent the plan from meeting a Clear Choice Design. They requested an example.

Bureau Response: In contrast to the EHB Benchmark Plan, which specifies a common set of benefits that must be included in all individual and small group plans, Clear Choice merely specifies the cost sharing to apply to a particular benefit if the carrier offers it. For example, adult vision is not a required benefit, and it is covered by some plans but not others. For those Clear Choice plans that do include it, the applicable cost sharing is shown in the "All Other" line in each column.

Comment: Community Health Options questioned the intent of Section 4(2)(C) and how it would apply. This paragraph provides that a carrier may have benefits not identified in a Clear Choice Design and continue to meet that design. However, Community Health Options observed that the proposed 2022 Clear Choice Plan Designs include an "All other benefits" line with designated cost sharing. MeAHP requested clarification whether chiropractic, acupuncture, and early intervention fall under that category, explaining that some of its members categorize chiropractors and acupuncturists as "Specialists" and suggest that these services should be classified accordingly.

Bureau Response: The Clear Choice plans proposed for 2022 include an "All Other" category. It is not required by the rule, but nobody has requested eliminating that category. Acupuncture, which these comments discussed, is another example of a benefit covered by some but not all plans, and according to MeAHP, the plans that do cover it are apparently divided between classifying it as "Specialist" or "All other." In cases where a covered service could reasonably fall within more than one category, the 2022 plan designs do not seek to micromanage the boundaries, and the carrier may assign the category that is consistent with its established practice. However, carriers should be mindful of applicable parity requirements. For example, 24-A M.R.S. § 2748 requires plans that provide coverage for a physician to cover similar services, when lawfully performed by a chiropractor, with consistent deductibles and coinsurance.

Comment: Community Health Options suggested a revision to Section 4(2)(E)(5) to permit other types of site-of-service incentives in addition to replacing coinsurance and deductible with copayments, such as a reduction in coinsurance or an elimination of the deductible. Community Health Options also requested the inclusion of incentive programs other than site-of-service, but did not give an example.

Bureau Response: This subparagraph, which is now Subparagraph (6), has been revised to clarify that replacing coinsurance and deductible with a copayment is simply an illustrative example. Other types of incentives will be evaluated on a case-by-case basis if proposed; the introductory paragraph of Section 4(2)(E) already uses the phrase "including but not limited to" to indicate that the list in Subparagraphs (1) through (6) is not exhaustive.

Section 5, Clear Choice Plans

Comment: MeAHP expressed concern that carriers "must offer CC plans in all metal tiers, however, if a plan decides not to offer in one, they must use one of their three possible alternatives to meet the proposed standard."

Bureau Response: That is not an accurate description of the requirements of the rule or the statute. Clear Choice designs are available for all metal levels, which permits, but does not require, carriers to offer coverage at any or all metal levels. Carriers are free to decide which metal levels to offer. The only constraints are the requirement that carriers that choose to participate in the Marketplace must offer both Silver and Gold plans, and carriers may not offer alternative plan designs at any metal level where they do not also offer a Clear Choice design.

Comment: According to Anthem, 24-A M.R.S. § 2793(2) "appears to contemplate annual rulemaking." However, Anthem observed that the proposed 2021 Clear Choice Plan Designs distributed in connection with the proposed rule have not actually been incorporated into the rule. Anthem asked how the process for development of Clear Choice plans established in Section 5(1) will be implemented in subsequent years, and whether the Bureau anticipates conducting new rulemaking each year.

Bureau Response: The requirement for rulemaking and the requirement for annual review of Clear Choice designs appear in separate subsections (2) and (3) of 24-A M.R.S. § 2793. The rule has been structured so that annual revisions to the cost-sharing designs can be made without further rulemaking. Amendments to the rule itself will be proposed if and when the Bureau determines that changes are necessary. Section 5(1)(A) has been revised to clarify our intent to publish a cost-sharing design chart, similar in structure to the 2022 chart, in time for carriers to use it in their filings each year.

Comment: Anthem requested a change to Section 5(1)(B), which as proposed prioritized changes to the deductible or maximum out-of-pocket expense if it was necessary for the Bureau to make adjustments to comply with changes to the federal AV calculation. Anthem stated that sometimes a minor adjustment to a copayment may be all that is needed to bring a plan into compliance. Anthem also urged the Bureau to consider setting a default AV for the Clear Choice plans, consistent with the approach taken in other states with respect to standardized plan designs and avoiding the potential for different results among carriers.

Bureau Response: The language prescribing the order of adjustments to copayments has been removed, and default AV calculations have been added to the table of cost-sharing designs.

Comment: We received a variety of comments on Section 5(1)(C), which governs Clear Choice plan names. AHA and ACS support the Bureau's use of clear, consistent language in the descriptive names of the plans, indicating the metal level or using the words "catastrophic" and "HSA" for those types of plans. They also support short, clear, easy-to-understand descriptions of these terms. MeAHP asked whether "High/Low" and "Clear Choice" need to be part of the plan names, and whether the short descriptive term could be the deductible amount. Anthem also asked about plan names including how to name the alternative plans.

Bureau Response: The intent is to have clear descriptive names, so "Clear Choice" must be used to indicate a standardized plan and the metal level. The deductible level may be used to describe the plan, and we have removed the terms "High" and "Low" from the descriptive names in our chart. Alternate plans do not have any naming conventions except to mention the metal level.

Comment: Harvard Pilgrim and Anthem objected to the requirement in Section 5(2)(A) that plans offered on the Marketplace must have an AV of at least 70%.

Bureau Response: The ACA premium subsidies are structured with the intent to ensure access to affordable coverage with an AV of 70%. That goal is frustrated if the second-cheapest Silver plan on the Marketplace has an AV that is materially lower. The Clear Choice suite includes an off-Marketplace design with a lower AV in order to allow unsubsidized consumers to buy less expensive policies if they choose.

Comment: Anthem asked which Silver plan is designated as the Basic Silver plan under Section 5(2), and also asked the Bureau to "clarify that any off-exchange version of an on-exchange silver plan is not subject to silver-loading."

Bureau Response: The Basic Silver plan for 2022 will be the Silver $3,500 plan, with a calculated actuarial value of 70.66%. Silver plans must have an AV at or above that level in order to be offered on the Marketplace. Any Silver Clear Choice design that a carrier offers on the Marketplace will be subject to silver-loading. The ACA does not permit a carrier to charge different prices for the same coverage to Marketplace and off-Marketplace customers. Section 5(2)(C) has been revised to clarify that if a carrier is permitted to offer a particular Clear Choice Design on the Marketplace, but chooses not to do so, silver-loading will not apply.

Comment: Anthem asked which non-HSA Silver plan is to be offered off exchange only. Community Health Options stated that the Clear Choice Cost-Sharing Plan Designs document should identify the High Silver Plan as an off-Marketplace-only plan.

Bureau Response: Section 5(2)(C) has been revised to eliminate the requirement to develop a Clear Choice design that is not an HSA plan. The Silver $5,000 plan (formerly designated as "High Silver") has a calculated actuarial value of 71.35%, so there is no reason to require it to be offered as an off-Marketplace plan. We have received no requests to provide an additional Silver plan design or to increase the cost sharing in the Silver $5,000 plan. There is less need for a variety of off-Marketplace Silver options in 2022 due to the expanded availability of premium subsidies, and each carrier remains free to designate any of its Clear Choice or Alternative Silver plan designs as an off-Marketplace plan.

Comment: Section 5(5)(A) provides: "The specified primary care office visit copayment shall be separate from any related laboratory charge from the visit." Anthem proposed making this provision optional, so that carriers can waive these cost shares under wellness or other incentive programs.

Bureau Response: We have changed "shall" to "may" as requested.

Comment: As proposed, Section 5(5)(C) would have required Clear Choice HSA plans to provide first-dollar coverage for all covered services that the IRS has determined to qualify as preventive care for tax purposes. Anthem requested that we revise this provision so that it applies only "if a carrier elects to provide first-dollar coverage for preventive services beyond what may be required pursuant to 24-A M.R.S. § 4320-A(3)." This is the provision of the Insurance Code mandating coverage of certain primary and behavioral health care services before the deductible. It does not currently apply to HSA plans, but will apply if and when the IRS provides guidance permitting coverage before the deductible as an additional preventive benefit. The Superintendent's request to approve this benefit for HSA plans remains pending at this time.

Bureau Response: This suggestion is consistent with the principle that Clear Choice does not create any new coverage mandates. We have adopted a version of Anthem's proposed language, which preserves carriers' ability to decide whether or not to provide additional pre-deductible coverage beyond the first-dollar preventive care that is mandated under current law. The citation has been changed from 24-A M.R.S. § 4320-A(3) to 24-A M.R.S. § 4320-A in its entirety, because the first-dollar benefits mandated by 24-A M.R.S. §§ 4320-A(1) already apply to HSA plans. In addition, we have changed the phrase "first-dollar" to "pre-deductible," because the benefits specified in 24-A M.R.S. § 4320-A(3) do not consist entirely of first-dollar benefits.

Comment: Anthem also noted what it described as "significant uncertainty around which services can be covered by HSA plans." Anthem recommended: "If the intent is to require HSA plans to cover the services, the Bureau must identify the specific services for which coverage must be provided in order to ensure that all carriers are providing coverage for the same services."

Bureau Response: Clear Choice only establishes the cost-sharing structure for the plans and does not specify which benefits must be covered.

Comment: Section 5(5)(D) requires office visits for behavioral health services to be categorized as Behavioral Health Outpatient Services, regardless of provider type. Anthem stated that it is not clear that this approach aligns with the quantitative testing requirements for compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), and that the processing of these claims process is dependent upon carrier reimbursement policies and provider billing practices, including whether an institutional claim form such as a UB 04 is used, or a professional claim form, a CMS 1500. Community Health Options supported Anthem's comment.

Bureau Response: This is precisely the sort of disparity Clear Choice was intended to address. The commenters have not explained how this requirement could violate MHPAEA, and the Clear Choice designs have been developed based on MHPAEA-compliant plans currently available in Maine.

Comment: Section 5(5)(E) specifies that the stated cost sharing for prescriptions is for a 30-day supply. Community Health Options sought clarification that a carrier has the option to provide a reduction in cost sharing for longer-term prescriptions; for example, payment for only a 60-day supply when a 90-day supply is provided through a mail-order program for insureds with chronic conditions. Community Health Options also asked whether this type of program would be permitted as site-of-service incentive program under what is now Section 4(2)(E)(6). Conversely, Anthem asked whether reduced cost for a 90-day mail-order supply is mandatory, or whether it is permissible to charge 3 times the cost sharing for a 30-day supply.

Bureau Response: This is permitted and has been clarified in the rule. It is entirely optional; there is nothing in the rule or the cost-sharing design chart that might be construed as requiring it.

Comment: Anthem noted that not all Tier 1 drugs are necessarily generic, while not all Tier 2 drugs are brand name, and asked whether Clear Choice plans were required to limit Tier 1 to generic drugs. Anthem also asked whether different pharmacies could be placed in different tiers.

Bureau Response: Although Pharmacy Tier 1 is labeled "Generic" in the 2022 Clear Choice design chart, this does not meant to prohibit carriers from including low-cost branded drugs within that tier, as long as patients are only charged the indicated Tier 1 cost sharing. Section 4(2)(E)(4) provides that tiered network plans may be offered as Clear Choice Plans as long as the specified cost sharing is offered at the broadest network tier and the networks is otherwise in compliance with applicable requirements. This includes tiered pharmacy networks.

Comment: Community Health Options asked whether Section 5(5)(F) is intended to permit certain services to be removed from the "All other benefits" category of the Clear Choice Cost-Sharing Plan Designs and to have the benefits provided at an appropriate benefit level of the carrier's choosing if not otherwise prohibited by either state or federal law. As an example, the company's Chronic Illness Support Program (CISP) provides diabetic members glucose testing with no cost sharing. Could glucose testing be removed from the category "All other benefits" and replaced with an Item "CISP – diabetic lab testing," which could be paid at any appropriate benefit level not otherwise prohibited? MeAHP mentioned Methadone Maintenance and asked whether it possible to consider this benefit as a differentiator and cover it in full. MeAHP also asked whether a site-of-service incentive could be offered for Outpatient Group Therapy, with a lower cost share than non-group therapy sessions.

Bureau Response: Yes, benefits may be more generous than required by the Clear Choice cost-sharing structure if not specifically stated or with specific value-based reasoning.

Comment: AHA and ACS recommend that the Bureau work with patient and consumer advocacy groups to seek input and feedback on the information the Bureau provides on its website related to Clear Choice Benefit Design options.

Bureau Response: The Bureau recognizes the need to continue working with consumers and other stakeholders to promote the Clear Choice plans and to develop updates in future years.

Comment: Anthem asked whether a Clear Choice plan can be offered at a higher metal level if an optional benefit raises its actuarial value to the range for that higher level. For example, if the addition of a preventive benefit causes a Bronze Clear Choice product to fall within the range for Silver plans, can that product be offered off exchange as a Silver plan? Alternatively, can the AV be calculated without inclusion of the additional benefit?

Bureau Response: The AV must be calculated in compliance with ACA requirements. If the carrier's modification to a Clear Choice design is so substantial as to change its metal level, it does not conform to an essential feature of the plan design. Thus, the Silver plan described in Anthem's example could only be offered as an Alternative Silver plan, not as a plan conforming to a Bronze Clear Choice design.

Section 7, Pediatric Dental

Comment: Community Health Options asked for clarification regarding the rules for offering pediatric dental plans.

Bureau Response: The rules are set by the ACA. Carriers are allowed to include dental benefits in any health plan. Off-Marketplace individual plans are required to include the essential pediatric dental coverage benefits, Stand-alone dental benefit plans that include the essential pediatric dental coverage benefits may be offered on the Marketplace, and as long as such plans are available, plans sold on the Marketplace are not required to include those benefits. As discussed earlier, the specified cost sharing applies if a benefit is included in the plan, but the inclusion of dental benefits in the cost-sharing chart does not create any mandate to add dental benefits to a plan that would not otherwise provide them.

Comment: Anthem, Community Health Options, and MeAHP all questioned proposed Section 7(1), which would have specified a separate $100 deductible for pediatric dental benefits. Anthem and MeAHP recommended allowing carriers to include dental benefits within the medical deductible, and Community Health Options requested the ability to offer a family deductible. MeAHP reported that some carriers would not be able to operationalize a separate pediatric dental deductible. Anthem also regards the inclusion of specific pediatric dental cost-sharing parameters within the rule as inconsistent with the Bureau's approach to medical benefits, which contemplates that the rule will only set general requirements and procedures, without dictating the specific cost-sharing designs.

Bureau Response: The pediatric dental deductible has been removed from the rule and the cost-sharing design chart. The coinsurance percentages are removed from the rule but remain in the cost-sharing design chart.